Appendix A

Mandatory Funding Split—Key to Maintaining Quality

The "Mandatory Funding Split" is the mechanism that allows market forces to function in Balanced Choice—while also protecting consumers from poor quality and high costs and providers from inadequate third party reimbursements.

The Mandatory Funding Split is the requirement that the Balanced Choice Board make continuing reimbursement adjustments, just as the Federal Reserve Board does when it adjusts interest rates. The Mandatory Funding Split serves to maintain quality care and economic stability without interfering with health care treatment.

Balanced Choice has two care Plans-the Standard Plan and the Independent Plan. Two-tiered systems have been rightly criticized because they are vulnerable to having the standard tier gradually starved of funding and deteriorating into substandard care for the poor. Public hospitals, public mental health systems, and recent cuts to Medicaid are examples of how health care systems are under-funded if they are seen as systems only for the poor. Maintaining quality in the Standard Plan depends on a mechanism that protects it from being starved of funds and, consequently, deteriorating.

The necessary protection is created by the Mandatory Funding Split which requires that the Balanced Choice Board set Standard Plan reimbursements and Independent Plan base payments (the amount Balanced Choice pays to providers) at rates that result in 60% of Balanced Choice funds going to the Standard Plan and 40% going to the Independent Plan, a 60/40 split. (In the initial phase, the split will be 75/25 because there will be a preponderance of low income beneficiaries. The split will gradually transition to the 60/40 split as Balanced Choice approaches 100% Colorado coverage.) Because consumers and providers have choice over whether they use the Standard Plan or the Independent Plan, Balanced Choice must maintain this 60/40 split without coercion. To maintain the Split, the Board must use reimbursement policies to entice consumers and providers to voluntarily select Plans in a manner that results in the 60/40 split.

How do reimbursement policies maintain the 60/40 split?
To understand how the Mandatory Funding Split protects funding for the Standard Plan, it is helpful to first review how the Standard Plan and Independent Plan providers are reimbursed.

- *Standard Plan reimbursement*—If the Standard Plan schedule sets a basic doctor's visit reimbursement at $100, in most cases the patient pays a $10 copayment and Balanced Choice pays the remaining $90 directly to the provider. For each visit, the Standard Plan has $90 credit toward its mandated 60%.
- *Independent Plan reimbursement*—Independent Plan reimbursement requires more math. Balanced Choice pays the Independent Plan provider a percentage of the Standard Plan fee, called a base payment. In this example, the Independent Plan reimbursement percentage is 85% of the Standard Plan of $100. Thus, Balanced Choice pays the Independent Plan doctor $85 as a base payment. If this doctor charges 115% of the Standard Plan fees, the doctor's full fee would be $115. The base amount paid by

Balanced Choice is $85 and the patient's gap payment is $30. For each visit, the Independent Plan has $85 credit towards the mandated 40%.

If the system starts deviate from the mandated 60/40 split, the Balanced Choice Board can make four adjustments to entice providers and consumers to make choices that restore the 60/40 split.

1. Increase Standard Plan reimbursements to entice more doctors to accept more Standard Plan patients (e.g., raise Standard Plan reimbursements 5%)
2. Decrease Standard Plan reimbursements to entice more doctors to only accept Independent Plan patients (e.g., lower Standard Plan reimbursements 5%)
3. Increase the base payments to Independent Plan providers by increasing the Independent Plan reimbursement percentage, which consequently decreases the gap payment and entices more patients to use the Independent Plan (e.g., increase Independent Plan reimbursement percentage from 85% to 90%)
4. Decrease the base payment to Independent Plan providers by decreasing the Independent Plan Reimbursement Percentage, which consequently increases the gap payment and discourages patients from using the Independent Plan (e.g., decrease Independent Plan reimbursement percentage from 90% to 85%)

Why is the Independent Plan base payment less than 100% of the Standard Plan reimbursement schedule?

In order to contain costs, it is important that the Independent Plan is never reimbursed 100% of the Standard Plan reimbursement. If 100% were covered, it would be too easy for providers to restrict themselves to the Independent Plan. They could do so by charging a slightly higher percentage rate than the Standard Plan (e.g., 102% of Standard Plan reimbursement). Very few providers would accept only Standard Plan reimbursement, and there would be no way to protect health care quality with so few providers. The Standard Plan could then indeed become substandard care for the poor.

In addition, if 100% transferred, it would encourage inflation. Most consumers would not hesitate to pay small increases, and it is the repetitive small increases in costs that are an important contributor to the escalation of health care costs.

Why is the split 60/40?

More Balanced Choice funds are likely to be spent in the Standard Plan for several reasons. All emergency room care is under the Standard Plan. Patients with catastrophic or chronic illnesses are more likely to use the Standard Plan because these illnesses impact income and raise health care expenses. The split should allow for these increased expenditures through the Standard Plan.

The concept of the split is key to providing the balance that makes the system successful; the exact ratio used to describe the split is illustrative, but fairly accurate. In the later phases of developing Balanced Choice, more detailed analysis and mathematical modeling may suggest that there be a different split.

Is it too complex to set reimbursement amounts for all medical services?

Currently, the Center for Medicaid and Medicare Services (CMS) already sets reimbursement amounts for all medical procedures for Medicare patients. In Balanced Choice, the Board would

assume responsibility for creating this reimbursement schedule and, in many cases, would begin by adopting the Medicare schedule. Where the reimbursement rates have been too low to attract quality providers, the Board could make the necessary increases.

Are the adjustments actually government price controls?
No, they are not price controls. Providers always have the alternative pricing structure of the Independent Plan. In fact, because of the Independent Plan, it is better to think of the reimbursement adjustments as policy decisions that follow the market. For example, jobs in the public sector often have salaries comparable to similar jobs in the private sector, and in this way the public job salaries follow the market. Likewise, if Independent Plan providers earn substantially more income than Standard Plan providers, the Board would be pressured to follow the market and raise Standard Plan reimbursements.

What effect do the adjustments have on inflation?
A mathematically sophisticated reader will be aware that the 60/40 split can be maintained with many combinations of Standard Plan reimbursement schedules and Independent Plan reimbursement percentages. If the Board set both of these too high, it could cause excessive inflation in health care, and if it set them too low, it could cause health care income to fall below the rate of inflation. In other words, because the Board would be able to either raise or lower both of these, adjustments could cause either inflation or deflation.

The Board would be required to set the combination of Standard Plan reimbursement schedule and Independent Plan reimbursement percentage at a point that resulted in overall health care provider incomes increasing at the same rate of inflation as the rest of the economy.

A portion of this Appendix is an excerpt from *Balanced Choice: A Common Sense Cure for the U. S. Health Care Systems.* Ivan J. Miller. (2006). Bloomington, ID: Authorhouse. For more information about Balanced Choice, visit: www.BalancedChoiceHealthCare.org.